

20 DEC 96

ANNUAL REPORT FROM ETHICS CONSULTANT TO THE NAVY SURGEON GENERAL

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1. Last year you took the initiative to have our panel, The Ethics Consultants to the Surgeons General, make a presentation to the TRICARE Executive Council. We were very grateful for that opportunity. Unfortunately, you were absent from that meeting. After the presentation, we were asked by Dr. Joseph to continue meeting with Dr. J. F. Mazzuchi, Deputy Assistant Secretary (Clinical Services). Three subsequent taskings have taken up most of our time:

a. That we make our rationales and specific recommendations on the Management of Pain and Suffering, Ventilator Withdrawal, and Sedation for Ventilator Withdrawal more elaborate for World Wide Web use. The Consultants finished this project in April and enclosure (1) through (3) were accepted and put on the DoD Health Affairs World Wide Web.

b. That we develop a position about privileged communications between military psychotherapists and non-active duty patients. Complaints had come to DoD that **information shared by family members** of active duty and retirees could not be considered confidential, and that this was having a very negative impact on therapy. Enclosure (4) is our response.

c. The Society of Medical Consultants to the Armed Forces (SMCAF), which originally recommended our formation, requested a position paper for an AMS Amicus Curiae Brief against Physician-Assisted Suicide which will be argued soon before the Supreme Court. We chose to expand on one salient point, rather than duplicate the voluminous material already available. Enclosure (5) was approved and accepted at the 1 November SMCAF meeting.

2. In an October meeting, Dr. Mazzuchi outlined his priority issues: a) Giving patients "futile" treatments; b) Managed care; c) Informed consent during combat; d) Genetic testing; e) Medical abortion; f) Disclosure Issues (Gulf War Syndrome). Since we meet **only quarterly and our time is rather** limited, these tasking would continue to take up most of our time.

3. During last year's brief, we discussed the value of being available to ethics committees for education and communicating state of the art ethics models for newly formed committees. Unfortunately, your gracious invitation for us to speak at the annual BUMED Directors Meeting, followed by my presentation at the annual BUMED Senior Chaplains Conference did not elicit many responses. Our energies after the TRICARE meeting have been focused on Dr. Mazzuchi's taskings and, with your concurrence, I will continue working on those with the other consultants. If you have other inclinations, I would appreciate your direction.

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ARE PAIN AND SUFFERING APPROPRIATELY MANAGED AT

YOUR FACILITY? -IN MOST, THEY ARE NOT

It is largely agreed that pain and suffering are typically underdiagnosed and undertreated. This is particularly true in-patients who are dying, but also in-patients with chronic illnesses. Relief of this pain and suffering is a primary duty of every health care professional. Optimal treatment involves a multidisciplinary approach that balances the risk of adverse effects with the benefits of effective pain relief.

In the care of patients in the terminal phases of their illness, pain relief often becomes the major goal of therapy, and the analysis of risk/benefit ratio needs to be critically reassessed. When patients are dying, it is important to recognize that fears of addiction are meaningless and should not be entertained. There is a tremendous difference between tolerance, which develops in-patients with chronic pain treated appropriately with narcotics, and addiction, which rarely occurs in these patients. **The sedation effect of analgesics is best discussed with patients when they have decision-making capacity; this permits them to choose how they will balance the value of interacting with friends and family members while feeling more pain against the value of maximal pain relief, but with significant sedation diminishing the ability to interact.** Patients may well request doses of analgesics that do not control their pain fully in order to meet a goal of continuing to interact with their families. Other means of controlling pain (such as supplementing opiates with non-steroidal inflammatory drugs, anticonvulsants, steroids, and antidepressants) should be explored in situations where control of pain is difficult.

Respiratory depression can be seen, particularly with large doses of analgesics. But in patients who develop tolerance to narcotics and require larger doses for adequate relief, the respiratory depressant effect is diminished as well, so even large doses of **narcotics required to control pain can most often be used without significantly decreasing the length of life the patient can have and may well increase** the ability of the patient to interact with family and friends. This should therefore not be viewed as assisting the patient in committing suicide. Caregivers should discuss with patients how they would balance the value of obtaining more relief from higher doses of analgesics against the diminished, though real, risk of respiratory depression. **As long as the goal of therapy is to relieve pain and the dosage is titrated to that level that will relieve pain but not be certain to cause death, even if the consequences of respiratory depression and the possible hastening of death are foreseen, the administration of adequate analgesia is appropriate and desirable.**

If a health care professional has significant moral discomfort and finds it impossible to participate in the care of such a patient, (s) he should attempt to transfer care of the patient to another member of the health care team and/or attempt to resolve the moral distress through ethics consultation or discussion with other

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Health care professionals. **If** a health care professional is able to identify this conflict early in the care of the patient, (s) he should discuss this with the patient as soon as possible and, if requested, transfer the patient to the care of another professional who can provide continuity of care.

While pain can contribute significantly to suffering (and efforts to address pain could certainly be more effective), suffering that is *emotional or psychological* is often the more significant and more difficult to control. Patients with chronic illness or terminal illness are particularly vulnerable to implicit suggestions about their lack of value or worth, especially in the current American culture; great value is placed on an individual's right to control their life, and on being young, healthy, and vigorous. When there is loss of function or loss of health, and this is unlikely to be reversed, great suffering can ensue. There may well be fear of abandonment or loss of control, fear that one will no longer be able to contribute, and this can lead to hopelessness and greatly increase suffering. **This suffering needs to be identified and treated at least as effectively as physical pain or other symptoms.** An example of this would be a previously active, dignified man who becomes increasingly dependent on others for mobility or even for feeding and toileting. He may not express the underlying reasons for his suffering, and **it will take an astute assessment of all these factors in his life to identify, and hopefully that, the cause of his distress.**

There have been remarkable advances in treating dying patients who desire hospice care, but there are many patients who are not in a terminal condition (and therefore not eligible for hospice) or who do not desire the restrictions placed by most hospices (i.e., DNR orders, etc.) but who request better control of pain and suffering. Patients and

families sometimes feel that the only choice available to them is either fully aggressive care or abandonment. This may aggravate the patient's suffering and be even more troubling for the patient and family. Respecting the patient requires that the health care professionals recognize and explore all possible means of treating these aspects of suffering.

There are many ways of addressing these concerns, including educational efforts directed toward all levels of medical training (beginning in medical school and sustained through continuing medical education), more involvement of patients and families in determining the goals of medical therapy, and a more active patient advocacy role for all health care professionals; all of these initiatives should be taken;

A promising alternative for advancing this goal in health care institutions is the formation of a multidisciplinary comfort care committee with exceptional expertise that can address issues in comfort care in a cohesive manner. This committee should include *physicians* knowledgeable and experienced in pain management; *nurses* experienced in cancer, AIDS, and hospice care; *pharmacists* knowledgeable about pain control management; *social workers* experienced in working with dying patients and their families; and *hospital chaplains* skillful in providing spiritual support to suffering patients and their families. **This team would also have**

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the necessary training in state-of-the-art methods for diagnosing pain and suffering and would be able to combine pharmacological, surgical, physical, psychosocial and spiritual means of achieving comprehensive care for these patients. While the initial impetus for such teams came from patients who were dying, this concept can and should extend to patients who are suffering from serious or life-threatening illness and those who suffer from chronic pain. Although many hospitals have developed "Pain Clinics", the scope of comfort care should be increased beyond mere pain control to be truly effective. Since the culture of modern medicine with its skewed emphasis on technological cure will only change through education, these committees should also be involved in educating health care professionals on the principles of effective pain control and comfort care. Skilled instruction on these issues will lead to better care for patients in military medical treatment facilities and should be fully supported.

Caring for patients in pain can be very challenging, but there is no place for the statement, "There is nothing further we can do." More effective attempts to provide comfort care are always appropriate, even when pain and suffering cannot be fully relieved; however, this goal is often inadequately pursued.

A particularly agonizing issue for health care professionals involving comfort care is whether to provide sedation during ventilator withdrawal may be viewed as active killing. This is further discussed in "Sedation for Ventilator Withdrawal: Is It Active Killing?"

Suggested Additional Reading

Cleveland CS, Gonin R, et. al. Pain and Its Treatment in Outpatients with Metastatic Cancer, N. Engl. J. Med. (1994) 330:592-96.

Foley KM, Inturrisi CE, "Analgesic Drug Therapy in Cancer Pain: Principles and Practice, Medical Clinics of North America (1987) 71:207-32.

American Health Consultants, Ethicists strive for acute ideological changes in care for the dying and "Pain education added to professional licensure," Medical Ethics Advisor (February, 1995) 11(2):13 - 9.

WITHDRAWING THE VENTILATOR: HOW DO YOU DECIDE?

Caregivers may be faced with internal conflict over whether it is ethically appropriate to accede to a request for ventilator withdrawal. There may be little in the way of such conflict when the patient is imminently dying or has lost virtually all capacity for cognition or relationship with others. However, when ventilator-dependent individuals are in full possession of mental faculties, are not imminently dying, and request discontinuation of their main source of life-support, there may well be varying degrees of clinician discomfort that death would be accelerated by complying with the patients wishes. **Under such circumstances—and particularly in view of the implication of hastening death—** must a caregiver accede to a patient's request for ventilator withdrawal?

On the one hand, it is fairly well established that any patient with decision making capacity may legally refuse any form of therapy, including life-prolonging therapy. Such patients may refuse to have ventilatory support initiated, or request the withdrawal of previously initiated ventilatory support, often justifying such preferences on the basis of intractable suffering or the need to maintain "dignity" or "control" in the circumstances preceding death. Such preferences stem from legitimate concerns, which should generally be accorded full respect.

On the other hand, caregivers may express considerable doubt over what may really be in the patient's best interests or what should be the proper response to such requests and thus legitimately question whether ventilator withdrawal is ethically appropriate. It may, for example, appear to the careprovider to be tantamount to assisted suicide. A single-minded focus on documenting patient preference may overlook or diminish the relative importance of such concerns, which should also be taken seriously.

Due to the ambiguities generated by these concerns, **special attention should be devoted to exploring the reasons** for requests for withdrawal from ventilator-dependent patients who are conscious. Since the underlying values, which govern deliberations over ventilator withdrawal, are often difficult to balance, any refusal of continued ventilatory support should be carefully *examined* and *fully informed*. A sensitive inquiry by careproviders familiar with the types of existential issues that commonly face severely disabled patients should be undertaken with a view to existential issues that could potentially mitigate a "firm" decision to request withdrawal of life support. Such **an inquiry** may include:

- Considering ways in which the patient's suffering—including *physiological factors (especially pain, anxiety, lack of dignity or "control" and despair—* may be adversely affecting the patients reasoning capacity, and assessing whether all feasible and appropriate measures have been taken to attenuate the patient's suffering, then *reassessing* the patients potential to adjust to suffering over time;

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- Recognizing the possibility of *enhancing* the patient's capacity to think, make choices, and relate to others while life remains—this may alleviate or reduce demands for the relief of suffering or preservation of dignity and control;
- Exploring the potential for developing new and achievable life goals that may accrue meaning over time for the patient who is not imminently dying.

Given that the roots of suffering are often remarkably complex, it can indeed be a daunting task to initiate and execute an inquiry of this kind with sensitivity and poise; ethics consultation may therefore help to address such concerns, involve the appropriate individuals in the decision making process, and achieve acceptable solutions. The following suggestions are therefore offered to help satisfy these important concerns:

- Identify those with moral standing in the life of the patient—family members, caregivers, and others—and when appropriate, engage each of them in the decision, if possible.

- Examine whether other alternatives to withdrawal such as time-limited trials of therapy to allow for the development of new and achievable life goals—are appropriate, and clearly establish the initial criteria for achieving these goals.

- Try to achieve consensus regarding the goals of therapy, while considering the potential for subtle individual or group coercion in arriving at consensus; the appropriateness of continued therapy should then be periodically reassessed and discussed at timely intervals.

If after these deliberations there is still significant ambivalence or disagreement over the propriety of ventilator withdrawal—and bedside ethics consultation has not yet been initiated—such consultation should then be seriously entertained to help mediate a solution to the dilemma. Any health care professional who for any reason is reluctant to participate in the ventilator withdrawal should be free to express such reservations and should not be required or coerced, either actively or passively, to participate in the withdrawal. In the event that ventilator withdrawal is held to be the appropriate response to the patient's request, see *further* "Sedation for Ventilator Withdrawal: Is It Active Killing?"

Mazel A, "Legal Myths About Terminating Life Support," Archives Internal. (1991)

151 :1497-1 502.

Herr SO, Bostrom BA, and Barton RS, No Place to Go: Refusal of Life-Sustaining

Treatment by Competent Persons with Physical Disabilities," *Issues in Law & Med.* ;

(1992), 8:3-36.

See, e.g., the outcomes of the two highly publicized in the synopses by Pence GE, Requests to Die Elizabeth Bouvia and Larry McAfee,' in *Classic Cases in Medical Ethics Second Edition* (McGraw-Hill, 1995), pp. 3441. Cassell EJ, "The Importance of Understanding Suffering for Clinical Ethics," *J Clinical Ethics* (1991) , 2:81 -82. «Further details and guidance may be found, e.g., in Loewy EH, "The Role of Suffering and Community in Clinical Ethics,' *J. Clinical Ethics* (1991), 2:83-89.

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SEDATION FOR VENTILATOR WITHDRAWAL: IS IT ACTIVE KILLING?

Given concerns about potentially accelerating a patient's death, is it appropriate to administer sedation for ventilator withdrawal? Any patient with decision making capacity may legally refuse any form of therapy, including the prolonging therapy. Under some circumstances such patients may refuse to have ventilatory support initiated, or requests the withdrawal of previously initiated ventilatory support. Health care professionals should explore the reasons for these requests and generally respect the patient's wishes (see further, "Withdrawing the Ventilator: How Do You Decide?").

Once the decision for ventilator withdrawal is made, the actual protocol for withdrawal needs to be examined. One of the very difficult decisions is whether to use sedation or not, and if so, in what doses. Since some patients (such as those with "locked-in" syndrome" or those with advanced ALS) typically continue to have full sensation and mental faculties until they die, the sensation of suffocating and the visceral responses to this can lead to great suffering. It is appropriate to treat this suffering with sedation and for analgesics, as long as the goal of therapy is to relieve or prevent the suffering, the dosage is not certain to cause death, and the patient's response to therapy is monitored to achieve the desired effect.

These decisions are among the most difficult in medicine, and the patient, the family, and health care providers should plan for and support the withdrawal in as compassionate and caring a manner as possible, with careful attention to the patient's desires. The goals of therapy, the actual protocols to be followed during a ventilator withdrawal, the personnel performing the withdrawal, and the timing and circumstances of the withdrawal should all be clearly discussed and specified prior to the actual event. The dose of medication-guided by the goals of therapy and response to sedation—should be titrated to sufficiently relieve discomfort related to suffocation during ventilator withdrawal but not to remove all ventilatory efforts.

When a provider has moral discomfort and prefers not to participate in the withdrawal process, (s) he should not be required or coerced to participate and ethics consultation should be considered.

Okay, so you've decided to sedate for ventilator withdraw l But should you be withdrawing it in the first place? If there is discomfort regarding the ethical propriety of the ventilator withdrawal itself, see further "Withdrawing the Ventilator: How Do You Decide?"

Reference:

Edwards MJ and Tolle SW, "Disconnecting a Ventilator at the Request of a Patient Who Knows He Will Then Die: The Doctor's Anguish," Annals Int. Med. (1992) 117:254 5B.

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MEMORANDUM FOR JOHN F MAZZUCHI, DEPUTY ASSISTANT SECRETARY OF
DEFENSE/CLINICAL SERVICES

SUBJECT Ethical Considerations Regarding Privileged Communications Between Military Psychotherapists and Patients Who Are Not on Active Duty Under current military regulations, psychotherapists in the military (on active duty or under contract with the DOD) cannot promise non-active duty patients (dependents of active duty and retirees) that the information these patients share will be maintained in confidence. The question presently at issue is whether the military need is sufficiently great to justify maintaining the absence of privilege for non-active duty patients in light of the harms this present policy brings about.

Discussion:

Ethically, the main arguments in favor of the present policy are military necessity and benefit to the military. The rationale for the absence of a patient/psychotherapist privilege is, however, much stronger for patients on active duty than for patients who are not on active duty. Empirically, the extent, if any, to which the present military policy regarding non-active duty patients benefits the military is uncertain.

On the other hand, the present policy **would** appear to be harmful in the following ways #:

(1) It impairs patients' dignity by forcing DOD psychotherapists to violate **patients' confidentiality, under** certain circumstances, by divulging even their most intimate revelations.

(2) It impairs patients' dignity by limiting the degree to which patients and their therapists can achieve a trusting relationship.

(3) It violates patients' equity by subjecting them to a different standard of care than their civilian counterparts.

(4) It impairs patients' care by limiting the areas in which they can feel free to discuss problems which concern them (and in which psychotherapists can feel free to inquire).

(2) It undermines military psychotherapists' morale by placing them in a position in which they must choose between their military and clinical loyalties. Presently, they must decide what, if any, discretion to use both during therapy and in regard to what they record in the chart.

(6) It harms active duty personnel, directly, and the military, indirectly, when now active duty patients do worse as a result of lacking privileged communication. This *is most* obvious, for example, when patients commit violent acts or attempt suicide. Active duty personnel are adversely affected, of course, whenever persons significant to them are emotionally troubled.

(7) It harms the military, directly, by reducing respect for military medicine within civilian medicine and society at large.

It is generally agreed that it is ethically unjustifiable to make decisions to avoid possibilities which are remote or improbable when actual harms are certain and substantial. (8) The harms listed above occur and are substantial. Accordingly, unless there are sufficient data to show that the theoretical goals of the present policy in regard to non-active duty patients are, in fact, achieved and that the achievement of these goals justifies the above harms, the present policy should be changed, and nonactive duty patients should be allowed patient/psychotherapist privilege.

Recommendation:

Non-active duty patient/DOD psychotherapist communication should be privileged, as it is in the civilian sector.

1. Wise, T.P., "Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff." Stanford Law Review 31:165-190, 1978.

2. Miller, R.D., "Miranda Comes to the Hospital: The Right to Remain Silent in Civil Commitment," Psychiatry 142:1074-1077, 1985.

3. Wulsin, L.R., "unexpected Clinical Features of the Tarasoff decision: the Therapeutic Alliance and the 'Duty to Warn,'" American Journal of Psychiatry 140:601-603, 1983.

4. "APA Questions Military Psychiatry Procedures." Psychiatric News. April 17, 1987:1.

5. "Mother Fights to Reep Daughter's Records in Rape Case Secret," n August 22, 1996:1.

6. Daniels A.K., "In the Service of the State: The Psychiatrist as Double Agent." Hastings Center/Report/Special Supplement 8:3-6, 1978.

7. Callahan, D.: "The Psychiatrist as Double Agent." Hastings Center Report 4:12-13, 1974.

8. Beauchamp, T. and Childress, J., Principles of Biomedical Ethics, 2nd Ed., New York: Oxford University Press at 233 (1982). Edmund C. Howe, M.D., J.D.

Chair, Ethics Consultants to the Surgeons General

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SOCIETY OF MEDICAL CONSULTANTS TO THE ARMED FORCES
PHYSICIAN-ASSISTED SUICIDE AMICUS CURIAE BRIEF

Fundamental Fallacy

- Overdependence on the doctrine of *informed consent*, based on the predominant role of the *right of self-determination* in medical decision-making in our society
- The analogy of Nuremburg—The *irrelevance* of informed consent in a hostage situation

Sources of Suffering and the Desire to Hasten Death

- Loss of control, humiliating dependency, and despair of meaning in life
- How should the physician respond? Eliminate all suffering or attempt provides comfort?

The Illusion of Control and Certainty in Assisted Death

- Who should decide whether life is still worth living? No one knows ahead of time or can control those outcomes the future holds
- Suffering and "Tunnel Vision:" Suffering can constrict one's perceived range of options, even when depression has been "ruled out"
- The consequent danger of physician *validation* by acceding to requests to hasten death

Authentic Advocacy

- Challenging "expressed preferences" may be indicated
- The importance of establishing a basis for empathic credibility to overcome the patient's strong perception of victimization and restore hope for further meaning in life
- Such advocacy is incompatible with a philosophy of radical autonomy Such advocacy may in fact *expand* autonomous choice

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Amicus Curiae Brief before the US Supreme Court on Physician Assisted Suicide

There is a fundamental fallacy underlying arguments in favor of physician assisted suicide. These arguments have relied heavily on the moral principle of *respect for autonomy* and the derivative principle, *informed consent*. However, these principles, useful as they are, are only *prima facie* "rules" and not at all absolute. Recent applications of these "rules" have made them appear to be "trump" principles; that is, under the rubric of constitutionally guaranteed rights to "privacy" and to "make one's own choice," autonomy has been used to override all other moral considerations.

It is important to understand the evolving history of informed consent to appreciate how the principle of autonomy achieved its current predominant role in decision making at the end of life. A turning point in modern emphasis on patients' right of self-determination was the trial of Nazi doctors at Nuremburg in 1947. The ten so-called Nuremburg Principles begin with a focus on "voluntary consent of the human subject." This focus on autonomy resulted from the fact that the horrible experiments imposed on inmates were conceived and carried out by respected members of the German medical and research professions.' The judges at Nuremburg had to consider who could be trusted in the future to observe reasonable restraint

in research involving human subjects.

At the time a first line of defense against violation of human sanctity seemed to be the preferences of the subjects themselves. However, we may have "overlooked the obvious." Informed consent alone cannot determine the moral propriety of actions to be performed. Sometimes it is not even relevant. Would atrocities perpetrated by the Nazi doctors have been morally justified or even *mitigated* if the subjects had consented to

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them in the context of their intractable suffering? While the appeal to autonomy may be used as a justification for hastening death, in this context of individuals held hostage, it was irrelevant.

Similarly, when the patient requesting assisted suicide is held hostage by intractable suffering, autonomy is important but should not be the overriding consideration. Requests to hasten death are made in the interests of *relieving suffering*. This suffering is often not related to physical pain, but rather due to loss of control, humiliating dependency on others, and despair. However, even when these conditions cannot be alleviated, a prudent physician can nearly always provide some comfort without eliminating the patient.

When patients have lost hope for meaning in life they may not be in the best position to determine whether life is still worth living. Elizabeth Bouvia and Larry McAfee chose to live after "winning" the right to hasten death. This demonstrates how fragile and presumptuous such a determination can be. The notion that an individual in the midst of intractable suffering can really know ahead of time what outcomes would hold future value, and can then control circumstances to achieve such outcomes, is illusory. Furthermore, suffering from a physically irreversible condition may have a profound influence on rational decision-making. This holds even when depression has been "ruled out" by tests standardized on non-comparable (i.e., not **irreversibly ill**) cohorts of patients. The impact of suffering in such an individual can create "tunnel vision" that

Jay A. Jacobson, et al., "Decedents' Reported Preferences for Physician-Assisted Death: A Survey of informants Listed on Death Certificates in Utah," 6 *Journal of Clinical Ethics* 149 (1995). See, for example, Eric J. Cassell, *The Nature of Suffering and the Goals Of Medicine* (New York: Oxford University Press, 1991). James S. Reitman, "The Debate on Assisted Suicide--Redefining Morally Appropriate Care for People with Intractable Suffering," 11 *Issues in Law & Medicine* 299 (1995). See discussions of the role of depression in requests for assisted suicide in Mark D. Sullivan and Stuart J. Younger, "Depression, Competence, and the Right to Refuse Lifesaving Medical Treatment," 151 *Am. J. Psychiatry* 971 (1994); Herbert Hendin and Gerald Klerman, "Physician-Assisted Suicide: The Dangers of Legalization," 150 *Am. J. Psychiatry* 143 (1993); David C. Clark, "Rational Suicide and People with Terminal Conditions or Disabilities," 8 *Issues in Law &*

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responds only to the appeal of hastening death. Under such circumstances, despair is often contagious, and it is therefore dangerous for the physician to validate such feelings by ever acceding to requests to hasten death.

Authentic advocacy on the part of the caregiver may require challenging the patient's "expressed preferences" to facilitate any possible means by which the patient may find new sources of meaning. This applies even when there is no hope for *physical* improvement. A critical responsibility for the physician is to establish over time a basis for empathic credibility and then—rather than continuing to validate the patient's despair—to attempt instead to overcome the patient's accruing sense of victimization. Such roles for the physician are incompatible with the philosophy of radical autonomy that underlies current advocacy for permitting physician-assisted suicide. Challenging "patient preference" may seem antithetical to fostering patient self-determination. Yet by helping to overcome the sense of hopelessness, such a challenge may actually facilitate the patient's search for meaning where none was previously perceived to exist. It may in fact *expand* the scope of authentic choices available to the patient.

Med. 147 (1992); Yeates Conwell and Eric D. Caine, "Rational Suicide and the Right to Die:

Reality and Myth," 325 N. Eng. J. Med. 1100 (1991). James S. Reitman, "A Wisdom Perspective on Advocacy for the Suicidal," in Gary P. Stewart and Timothy J. Demy, eds., *Suicide and the Christian Community: An Ethical Dilemma* (Grand Rapids, MI: Kregel Publications, 1997), forthcoming. *Ibid.*; see also Jay Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1984), at 121-25, 159-63.